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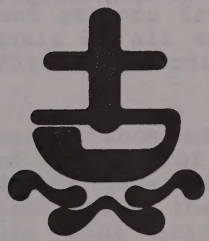
AIDS and THE CHURCH

HEARING ON AIDS

Central Committee
Geneva, January 1987



WORLD COUNCIL OF CHURCHES

Programme Unit on Faith and Witness

Sub-unit on Church and Society

Moderator: .The Most Rev. John Habgood, Archbishop of York

Panel: .Dr Jonathan Mann, World Health Organisation

.The Most Rev. Edmond Browning, Presiding Bishop Episcopal Church, USA

.Dr Bena-Silu, Member WCC Executive Committee

.Dr Kevin Gordon, Roman Catholic Systematic Theologian, Union Theological Seminary, New York.

Introduction

During 1986 the World Council of Churches gave serious attention to the escalation of the Aids epidemic and its implications for the churches, and in January 1987 the sub-unit on Church and Society organised a Hearing on the subject for the Central Committee. What follows is the edited text of that Hearing; the following recommendation was unanimously approved by the Central Committee:

> The Central Committee of the WCC urges all churches to make known the seriousness of the problem of Aids and to take every opportunity to cooperate with one another and with medical, social and educational agencies and the mass media in appropriate educational programmes.

As part of our response to the Central Committee's call we are publishing in four languages the most up-to-date and reliable information made available to us at the Hearing together with the document "Aids and the Church as a Healing Community" based on an ecumenical consultation on Ethics and Aids held in June 1986 in Cartigny, Switzerland. This consultation, which was co-sponsored by three sections of the WCC (Church & Society, Family Education and the Christian Medical Commission) may well have been unique in that it brought together medical, ethical and theological experts and pastors from three continents; its findings have been the basis of all subsequent WCC statements about Aids, and its edited proceedings are in process of publication.

The Central Committee Hearing took advantage of the presence together of distinguished members of the WCC's Central and Executive Committees and the proximity of the World Health Organisation, which had been one of the main stimulators of the WCC in responding to the Aids crisis. Dr Jonathan Mann, Director of the WHO's Aids programme, opened the session by summarising the most up-to-date and authoritative global information available. Bishop Edmond Browning, Presiding Bishop of the US Episcopalians, shared the experiences of US churches in coping with the problem. Dr Bena-Silu, a nuclear scientist from Zaïre and a member of the WCC Executive, gave an account of the situation in West Africa. Dr Kevin Gordon, a Roman Catholic lay theologian undertaking research in systematic theology at Union Theological Seminary in New York, who had also chaired the earlier June consultation, came specially for the occasion, which was moderated by Dr John Habgood, Archbishop of York and moderator of the Church & Society Working Committee.

During the following week, January 19-24, the sub-group of Unit I dealing with Church & Society issues, discussed the findings of the June consultation in the light of the Hearing in order

to bring them up-to-date. Their work was approved by the Unit I plenary and presented to the full Central Committee plenary on Saturday January 24th., where it was unanimously endorsed. This summary is appended to the Hearing together with the final speech before the vote by Dr Kevin Gordon.

It is informative to trace briefly the stages whereby this deeply tragic issue appeared on the ecumenical agenda. In late 1986/early 1987 several North Atlantic churches and the WHO approached the General Secretary with a request that the WCC should study the problem which, the WHO maintained, was being aggravated by certain fundamentalist groups which were discouraging the allocation of funds for research on Aids on the grounds that the disease was God's judgement on homosexuals.

The General Secretary responded by asking three sub-units of the WCC, Church & Society, Family Education and the Christian Medical Commission, to explore the matter and report to the March Executive meeting in Zaïre - which at that time was beginning to experience a high incidence of Aids cases which could only have been caused by heterosexual transmission. In June 1986 the three sub-units called a joint consultation at which the General Secretary, Dr Emilio Castro, in an opening address, challenged the view that disease is a punishment from God: "Aids is a disease and should be treated as such....God, who loves all human beings, cares for the well-being and health of everyone of his children, and does not inflict disease as a punishment", he said.

The final statement of the June consultation, which emerged from a painful and often deeply emotional encounter between conflicting viewpoints and commitments, called for the Church to be the Healing Community, expressing its solidarity with those affected by Aids through pastoral care, education for prevention and social ministry:

> "In the mysteries of life and death we encounter God; this encounter calls forth trust, hope and awe rather than paralysis and immobilization. Those we cannot cure we can support and sustain in solidarity: 'I was hungry... thirsty... a stranger... naked... sick... imprisoned, and you fed... clothed... took care...visited'(Matthew 25).
>
> "The Aids crisis challenges us profoundly to be the Church in deed and in truth: <u>to be the Church as a healing community</u>. Aids is heartbreaking and challenges the churches to break their own hearts, to repent of inactivity and of rigid moralisms. Since Aids cuts across race, class, gender, age, sexual orientation and sexual expression, it challenges our fears and exclusions. The healing community

> itself will need to be healed by the forgiveness of Christ."

The June consultation statement was reviewed by the Church & Society Working Committee at its July meeting in Potsdam and forwarded to the September Executive of the WCC meeting in Iceland. The Executive endorsed the earlier work underlining three major concerns of the consultation urging the churches

> "to confess that churches as institutions have been slow to speak and to act; that many Christians have been quick to judge and condemn many of the people who have fallen prey to the disease; and that through their silence, many churches share responsibility for the fear that has swept our world more quickly than the virus itself;
>
> "to affirm and support the entire medical and research community in its efforts to combat the disease;
>
> "to affirm that God deals with us in love and mercy and that we are therefore freed from simplistic moralizing about those who are attacked by the virus".

Several members of the Executive expressed their appreciation for the appropriate timing and painstaking work of the consultation, and the approved statement was sent out to the churches by the General Secretary on October 9th., 1986 for study and appropriate response. At the time of the Hearing three replies had been received from the Episcopal Church of the USA, the Anglican Church of Canada, and the Evangelical Lutheran Church in Tanzania. It is expected that when more have come in they will be summarised and made available in appropriate languages so that churches which have had an early opportunity to respond to the crisis will be enabled to share their experiences with those who are just beginning to feel the impact.

A recent publication produced by the London-based Panos Institute in association with the Norwegian Red Cross, paints a grim picture of the way humanity's Aids frontline has now shifted decisively from North Atlantic countries to Africa and that "the great majority of those already marked for death live in the Third World" (Aids and the Third World, see recommended reading list at end). The anticipated consequences are spelled out in Jonathan Mann's opening address to the Hearing - maybe as many as between 2 and 5 million Africans already infected, for example. In such a situation the churches have an enormous potential role to play - as much in developing countries as in Europe and North America - in disseminating accurate information about how the virus is spread and how people can

protect themselves. We hope that this short publication will be a small contribution to this process.

We wish to thank all the speakers at the Hearing, especially Dr Kevin Gordon, who came over from New York at very short notice, and also once again the members of the international consultation which met last June and pioneered the way so painstakingly for all later WCC statements about Aids. And we wish to express our special gratitude to Dr Cecile de Sweemer, now working with the International Development Research Centre in Senegal, for her outstanding contribution and commitment to this part of the Council's work.

David Gosling
Director
Sub-unit on Church & Society

HEARING ON AIDS

The Most Rev. John Habgood (Moderator)

This is a Hearing and by that is meant that it is primarily for the exchange of information, which is why we have invited experts who can help us to understand the problems that we are going to discuss. I shall ask each of them to speak briefly first and then I hope there will be time for questions.

Let me begin with a picture - a picture drawn from the Scriptures. You remember the passage in the Old Testament where the Prophet Elijah sees a cloud no larger than a man's hand which in a very short time filled the whole heaven with storm clouds. I think that is a very apt description now of where the world stands in relation to Aids. For some, this seems a very small cloud on the horizon. All the evidence is that in a few years it will be a storm cloud which covers the whole sky and deeply affects the life of all countries. Now with that rather sombre introduction I am going to ask Dr Mann of the World Health Organisation (WHO) to put us in the picture from a world perspective.

Dr Jonathan Mann

I very much appreciate this opportunity to have a chance to speak with you about this. I've divided my very brief presentation into three parts. First, I shall give you some of the facts and figures and estimates that we have developed at the WHO regarding the scope of the problem. Then I shall talk briefly about the impact of this problem beyond the health statistics - the impact again as seen from the WHO. Thirdly I shall briefly talk about Aids prevention and control. In other words what is underway now and what do we see coming underway in order to help deal with this problem, again from the WHO perspective.

First to talk about the global scope. This disease was first recognized in the United States in 1981. By the end of 1982 there were about 700 cases of Aids reported from 16 countries. There are now about 39,000 Aids cases reported from 85 countries around the world. These 85 countries come from all continents. The number of Aids cases has increased by a factor of more than 50 during the last four years.

When we look at a problem in terms of worldwide scope there are relatively few diseases of this kind that affect this number of countries on all continents. I'd like to briefly do a quick tour of the world with some emphasis on areas that you may not have heard too much about regarding Aids. In the Americas, first of all, looking at the entire hemisphere, 33 countries have reported Aids cases. The Aids picture in the Americas is indeed dominated by the United States. But other countries with substantial numbers of officially reported cases

include Canada, Brazil, Mexico, Haiti, and Trinidad and Tobago. However, there are another 27 countries that have reported between 1 and 68 cases each.

Now I should remind you about two things about Aids cases. First, the number of reported cases is always a portion and usually not a complete picture of the number of actual cases occurring in the country for a variety of reasons. And secondly, when you look at the number of Aids cases, in a sense, you are looking at the wrong number because of the long incubation period, in other words, the long period from the time of infection to the time the disease becomes obvious which may be a matter of years. When you look at the number of Aids cases you are really seeing what was happening with the virus that causes Aids 4 to 5 years earlier. So its the wrong number to focus upon because it minimizes the problem that you actually face at any point in time. In the United States there have been 29,000 Aids cases and it is estimated that by 1991 there will have been 170,000 Aids cases in that country. More than approximately a ten-fold increase during the next four and a half years.

Now to turn to Europe. There have been approximately 4,000 cases of Aids reported from Europe thus far. It is however estimated there are between 500,000 and a million Europeans currently infected with the virus that causes Aids. Once again the scope of the number of people infected is much larger than the number of actual cases. It is estimated that in Europe, by the end of 1988, there will have been a total of 25,000 to 30,000 cases of Aids.

Now let's turn to Asia. In Asia, the Aids virus is just beginning to appear. There have been fewer than 100 cases of Aids reported from 10 countries in Asia. We know, however, from other studies, that the Aids virus is present in Asia and yet it does not appear to have penetrated into the large populations of Asia yet. So, one way of putting it is that Aids is knocking upon the door of Asia. It has not yet entered in a strong way.

Africa is the continent of the world clearly most severely affected at this point in time with the Aids virus. Although only 2,300 cases of Aids have been officially reported to the WHO from 17 different countries, we know that the scope of the problem is much greater. The WHO estimates that there are probably between two and five million Africans infected with the Aids virus today. I would remind you, however, that there are one and a half and two million infected Americans with the virus today. The studies in Africa have shown that in parts of Central, Eastern and Southern Africa between 2 and 15% of healthy adults in the population appear to be infected with the Aids virus.

If we look now at Oceania, the cases that have thus far been reported are from Australia and New Zealand. However, we have

reason to believe that other parts of the Pacific and other regions also have already experienced Aids cases. There's no reason why there should not be more because this disease is transmitted sexually from any infected person to their sexual partner, that is, not only homosexually but heterosexually - from man to woman and woman to man. It is also transmitted through blood if the blood is not screened for transfusion, and it's transmitted through injections and from mother to child. If you have a disease that is transmitted in those ways, you have a disease that is likely to be transmitted around the world. The WHO estimates that there are between five and ten million people infected now with the Aids virus. We therefore estimate there is likely to be between a half a million and three million additional new cases of the Aids disease during the next five years.

The impact of Aids goes far beyond the health statistics - far beyond the numbers that I've just quoted. What I have just quoted to you, in fact, is the evidence that supports the idea that there is a worldwide epidemic underway. This is an epidemic first of infection with the virus and only years later does the epidemic of the disease Aids become apparent. The impact extends through the personal and family level. There have been tragedies at the personal and family level throughout the world as a result of fear and ignorance about this disease. At the social level, because people 20 to 40 years old are most severely affected, you see in societies the loss of mothers and fathers. You see the loss of productive people in the most productive years of their life. You therefore have a threat - a direct threat to economic and social development which depends upon people who have been trained and formed in a society and which society is now hoping to receive the benefits of that training back. When you lose a neuro-surgeon, for example, in a developing country, you have lost a very precious and unusual resource in terms of social investment.

In addition, we are seeing another impact worldwide - the impact of stigmatisation. This is an impact that takes place on many levels. On one level it takes place because individual people - whether they be male homosexuals or bisexuals, female prostitutes, hemophiliacs, Westerners, Africans - it all depends where you are in the world - are stigmatised. Stigmatisation has been an unfortunate feature of this disease and of this epidemic. Everybody believes it's somebody else's problem, that it comes from somewhere else, it doesn't affect them and they want it to be a problem they don't have to deal with. And that leads to stigmatisation. And on the international level it leads to proposals to screen people and prohibit the free movement of people on the basis of whether they are infected or not - an idea which has no justification in concepts of disease prevention.

There's also a threat to children that I want to emphasize. Because Aids is a sexually transmitted disease, women of childbearing age are infected. And infected women have about a

one in two chance of infecting their new-born child. Therefore, in parts of the world, parts for example, of Central and Eastern Africa where upto (this is not everywhere) 10% of pregnant women are infected, upto 5% of the children being born may be born infected with Aids. In addition, children who are particularly susceptible to diseases like malaria will also receive injections which may be given with needles which are not sterile and blood transfusions which if they are not screened can transmit the virus. Therefore Aids represents worldwide not only a threat to development, economic and social, but a specific threat to children.

To say a final word about prevention and control. In order to even think about global prevention and control of Aids, the problem has to be recognised for what it is. And this is where the image evoked of a small cloud becoming a storm is appropriate. You could call 1986 the year of global Aids awareness. This is the year during which for the first time populations and governments began to realise that this is truly an international problem of international dimensions. People want so terribly to believe that this disease will not affect them. I wish it were true. The evidence is clear. This disease is spreading rapidly into parts of the world where it did not exist before and it is spreading and becoming more serious in those parts of the world in which it is already present.

The other critical factor from the World Health Organisation viewpoint is the attitude within our organisation. Two years ago the WHO did not consider Aids a priority. On November 20, 1986, Dr Mahler, Director General of WHO in New York, indicated that with the same commitment to global purpose with which the WHO had addressed small-pox eradication in the past it is now beginning to commit itself to the much more urgent, complex and costly objective of global Aids control. The WHO now sees Aids as a worldwide problem of unprecedented importance and urgency.

To conclude. This is a problem of global scope. The consequences for the individual, the family and society of infection with the Aids virus are profound. We do not have a vaccine. We do not have a cure. We obviously hope we will, but we do not have either yet. And millions of people are already infected, and millions more will be infected during the next few years unless we can achieve a form of control that is based on education. The unprecedented urgency and importance of this problem will require unprecedented creativity, energy and resources. So, from the WHO's viewpoint, we welcome any opportunity to collaborate and cooperate with you, and with your organisation in what we see as a global health problem of unprecedented urgency and proportion. We hope that the WHO can be useful to you and I offer our services to you in any way we can to help you as we try to deal with this global problem that affects not just the health statistics but in a very real way the entire social and intellectual and personal lives of people and societies.

Moderator

Thank you very much. It's obvious from what Dr Mann has said that this is a problem in which the churches must be involved. It's a human problem, a problem of suffering, a problem in which our educational role is extremely important. And that's why we've got two speakers now from the United States because it is there that in the first instance the problems have begun to be tackled on a large scale.

Dr Kevin Gordon is going to tell us something from the perspective of a WCC consultation which he moderated last June, and from his experience in the USA.

Dr Kevin Gordon

I'd like to make my comments as the chair of the Consultation on Ethics and Aids that was called together in June 1986 by the World Council of Churches. I chaired a group of 18 persons from three continents and I would like to make my comments not only as the chairperson but as a systematic theologian and a church person. I'll make my comments against the fairly easy rubric of the past, the present and the future, but in the sequence of the past, the future and the present. To begin with the past, I truly want to give gratitude and thanks and appreciation most sincerely to the WCC because I think they had the foresight and indeed the courage to call together a consultation for consideration of these difficulties even before we saw the magnitude of what Dr Mann has just explained to us. Also, the fortitude and the courage at a time when this disease was largely seen to be the preserve of stigmatised people, whether homosexuals, drug-users or others. And for that commitment of the WCC to address a very controversial issue not fully understood even then and perhaps not then worthy of that kind of sustained attention, I congratulate them for a seriousness that has enabled me to continue to communicate with them from the beginnings of that statement until the present.

As I move from the past to the future I will not reiterate what Dr Mann has said but simply emphasize that serious as this issue was at the time of the consultation in June of '86, even then we did not see the urgency of what is before us now. Even as we wrote that statement and we struggled with different points of view from three continents, we did not know then that indeed while there was underreporting, and we knew that, we were still only working with a number of 30,000 cases diagnosed in the world. We were talking about Africa with 1,000 cases. We know we're talking now about a good 50,000 cases. We're talking about a situation in the United States in which it is estimated and acknowledged that we will have a catastrophe on our hands with a probable 179,000 people with Aids by 1990. I leave the future under this rubric simply to emphasize that the urgency that we had even then was miniscule in terms of the

efforts that we must have and we must continue to sustain. In terms of the document that came from the June consultation on Aids, and that is the basis of all subsequent statements from the WCC, I make just the following few comments.*

It seems to me that it is a straightforward document. It limits itself to the essentials. It emphasizes that we must have education for prevention and that such education must be explicit about the sexual modes of transmission of what is indeed a sexually transmitted disease.

It has a section on social ministry which is an obvious need and it will only become more complex because the possibilities for oppression and discrimination whether in immigration, housing, employment, or health insurance, there are sections of the globe that are just beginning to suspect the kinds of social ethical issues that this disease generates. And it seems to be that the churches are a natural resource so that we do not continue to reinvent the wheel, but that we can learn from those parts of the world which have first had to struggle with this disease and at least in a preliminary way try to discern a humane and indeed Christian approach mindful of the dignity of human persons and the reality of human and civil rights.

Of major importance to myself as a theologian is what we try to establish as the theological foundations of this document and the approach of the churches. Let me say a word about that. I think the document is important not only in what it says but what it managed not to say. It basically appeals to Matthew 25, and it says what we cannot cure we can stand under and we can carry. It appeals to the churches to withhold rigourism and moral judgements. It appeals, though not explicitly in this document but very much in the spirit of our deliberations, to the experience of Job. In the situation of Aids we stand before profound incomprehensibility and hard questions. Let us spare people our easy answers and facile moralizing. Let us with Job in the long run put our finger to our lips if we have no real answer. Let us not manufacture easy answers. But let us get on with feeding the sick and burying the dead.

It seems to me that this crisis for the churches encourages us to follow our own best genius and not become our own worst enemies. And what indeed is the genius of Judeo-Christianity? The genius of Judeo-Christianity is that we have a predilection. Our predilection is for the orphan and the widow, the dispossessed and the disenfranchised. Our ultimate predilection is for the last and least woman and man on earth, without judgement, without care for who is righteous, but to do what must be done.

The churches have often had great difficulty talking about

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*"Aids and the Church as a Healing Community", see page 24.

human sexuality. This is because they have problems dealing with pleasure and the underlying issue of passion. We must not let our own difficulties about speaking honestly about the human phenomenon of human sexuality get in the way of the absolutely explicit sexual education we must give people if this disease is not to continue to spread. Secular society has its own problems with sex education - and this is especially true in the United States - but we should not use it as our yardstick. Let me give two quick examples of what we must and must not do.

I want to very much applaud the Episcopal Church in the United States for very courageously generating grassroots mechanisms that have responded to this crisis. There was a young man in San Francisco who had moved to Florida for about four months, contracted Aids and was deported, if you will, sent back from Florida to San Francisco to be taken care of. Very much a question of the hospitals not wanting to deal with him. This person was unchurched. When he died the Episcopal bishop of California invited the lesbian and gay community of San Francisco to have a funeral service that he presided at himself, very much with this thought: there is no last and there is no least, that if this person is able to go unnoticed and unattended then we all live unaffirmed. And as with Israel in affirming the one all are affirmed. That is a model of what we will do.

In my own tradition of Roman Catholicism I give one unfortunate example of what will not do. And that is the withdrawal of support by the Roman Catholic Archdiocese of Los Angeles. Withdrawal of support recently for Aids projects because of advocacy of the use of condoms. I do not think that we have the leisure for those kinds of distinctions at this crucial point.

So I congratulate the WCC for its initiatives in raising this difficult issue. But I would certainly hope that we realise that while it may have first seemed that this disease, which has shown up in unpopular pockets of society and with difficult modes of transmission, while it might initially have seemed that we are going to judge Aids, time will show that Aids will judge the churches. And I do hope that this statement will not simply be words, indeed even good words, but that this is our commitment as an organisation to sustained programmatic effort to overcome the epidemic of the century.

Bishop Edmond Browning

I don't want to repeat what either Dr Gordon or Dr Mann has said. But I would like to begin by picking up from Dr Gordon when he pointed to the example of our bishop in the diocese of California. The interesting thing for me about the Episcopal Church's response to the question of Aids is that it has not been something that has been initiated by our national organisation, but has been really a response initiated by the local church in the local diocese. It's been initiated by

people who have been very close to the problem and the suffering of both the people who have Aids as well as their families. And I think it is extremely important to understand the context within which we have produced this programme.

But having said that, I would add that there has been a group of our bishops especially the bishops of New York, Chicago, Los Angeles, and San Francisco who began sharing their experiences of the suffering involved in this problem, and subsequent to that sharing which began in 1984, at our General Convention in 1985, a resolution was presented to the Convention for our national church to develop a programme and a response to the issue of Aids. That was responded to by the General Convention which is a body of bishops, clergy and laity of some 1200 people, which almost unanimously recommended a pastoral response.

Our response has been basically in four areas. Firstly, an educational approach. Secondly, the development of pastoral care. Thirdly, advocacy within our own society particularly with our government, calling upon our government for funds for research and for long-term medical care. And a fourth area which we've not really got into yet, but we're in the process - it's the next phase of our programme and that's the issue of public health/prevention including behaviour modification and values.

Just to share with you briefly some information about the education programme. We feel out of the experience that has come out of the congregations as well as the diocese that the most important issue in terms of education is trying to deal with the prejudices around the issue of Aids that are held by many, many people. On November 9th., 1986 I called for a national day of prayer in all of our congregations. This was responded to with a great deal of enthusiasm because of what it did for the person in the pew and that person's understanding of the issue of Aids. We prepared a brief brochure about the questions of how one gets Aids, where Aids originates, some of the prejudices around the issue, ways of facilitating relevant worship, how to pray for people with Aids as well as members of their families. So I brought copies of these along to share with you.*

I think probably that one of the exciting things for me has been the pastoral response that has been made throughout the whole American Episcopal Church. Dr Gordon gave you one example from the diocese of California. The diocese of Houston in the State of Texas is another. This diocese has established a hospice for persons with Aids so that they can die in a truly family caring situation. The hospice also deals with the tremendous cost. I will share with you parenthetically that the cost of an Aids patient runs something in the neighbourhood of $ 600,000 from the period of entering a hospital to the time that person dies.

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*See recommended reading list at end.

I will just conclude by saying that we see it is a real issue of how the church assists people in their dying. And how they are brought to a sense of peace and a feeling of acceptance and love by the Body of Christ.

Moderator

Now let's continue the formal input with a word from Africa. Dr Bena-Silu is a nuclear physicist from Zaïre and also a member of the Church & Society Working Committee. Are you aware of much thought being given to this problem in your own continent?

Dr Bena-Silu

I would say yes because in the previous days at the end of 1981 it was said that Aids first started in Africa. Then we began hearing different theories that it may not have started in Africa, maybe in Latin America or somewhere else. So Zaïre is one of the very few countries in Africa where efforts have been made by the government to have the people informed about not only the spread of the disease but also as to the way to prevent it. In Kinshasa we have an international team in which French, American and Soviet researchers are involved in one of our main hospitals not only to undertake research but also to obtain data about the spread of the disease. This is the current situation and from time to time the media brings everybody up to date.

Dr Mann

This provides me with the opportunity to say that Zaïre is actually a good example to be followed. Zaïre has really been a leader. And I know what I'm talking about because for two years I was the leader of the research team that you just referred to. I was in Kinshasa for two years and worked with French, at that time French and Belgian, but particularly Zaïrian researchers and American researchers to examine the issues of Aids in Zaïre. And Zaïre had the courage to open itself and its scientific institutions to international collaboration, which means that the government of Zaïre knows more about Aids than most governments in the world because of the information that has been developed by these teams. So, first, this gives me a chance to again congratulate Zaïre for its thinking and its action on Aids.

Regarding research and this is connected to what I just said, the Zaïrian research teams have in fact produced some great steps forward in research on Aids vaccine and on Aids treatment. The scientific world is awaiting some of the conclusions and some of the results of these studies that have been undertaken in Zaïre with international collaboration. We all hope that some of the answers to this problem will come through some of the work in Zaïre. But having said that I have to be realistic. Realistic that a vaccine that is safe and

effective and can be used for the millions of people who need it is predicted to be at least 5 years away even if the Zaïrian work proves to be as exciting in its conclusions as it appears to be. Treatment - there have been treatment advances reported from various countries in the world but we believe that treatment, a safe and effective treatment, is also probably years away. Therefore, for the next five to ten years prevention is likely to be exclusively a matter of education. We hope that there will be a vaccine and a treatment and, again, the work in Zaïre is helping to move the whole world faster in that direction.

Question

I have two questions. The first one concerns the churches. As far as I understand Aids can be spread by blood contact. If someone bleeds from the mouth and we all receive Holy Communion from the same cup, some blood could come into the cup and the next person drinking it would be affected. Do you think this is correct and will it have any effect on the churches? The second question: I hear that the virus is changing and I heard somebody say that it can be carried by eating from the same plate or using the same toilet seat.

Dr Mann

Regarding the first question. To me, in my profession, I see that as a question - is the virus transmitted through saliva? That's the general way I would like to interpret your first question. The answer appears to be "no". We have to distinguish here between theoretic possibility and what actually happens in the world. The issue is the same with tears. The virus is present in some infected people in their tears. And so the question was raised in the United States: Can a teacher safely wipe away the tears of a young child? Fortunately, in the world, the real biological world in which we live, theoretical possibilities do not always translate into actual realities. You might think, for example that if people live in the same household where they not only share the same glass from time to time but they also use the same towel and may even rub against each other a lot during the course of the day - you might think that in such a household the virus could be spread because it is present in the saliva of an infected person and it is present in tears, etc. But fortunately, all the medical studies that have been done whether in Africa or in Europe or in the United States have shown that the virus does not spread through what we call casual contacts which includes all the things we do in our daily lives with other people such as shaking hands, and it actually even includes sharing a cup and, of course, includes sharing toilet seats and working next to people, etc. So, theoretically, there could be a theoretical concern . In practice it is agreed that the risk of transmission through the route you just mentioned while theoretically possible is extraordinarily unlikely because in medicine we can never say "never".

Now, regarding the second question. Could the virus change? I think we have to be very aggressive in our response to that. Yes, of course, it could change. We also could have a new epidemic tomorrow with a virus that was spread through the air and through touch. But to evoke that fear, in my opinion, is to unfairly evoke fear that is unjustified. It is up to us to continue looking to make sure that if evidence emerges that it is transmitted by mosquitoes, by shaking hands, by toilet seats, that that information is shared. But until that information becomes available to evoke the possibility, in the absence of any proof, I think is to frighten people about something they are already extremely frightened about. So medically there is no evidence of the virus' changing in a way that would affect the way it spreads. We will keep our ears and eyes open. But at this point I think we should insist that the virus is only spread in three ways: sexually, through intimate blood contact by which I mean blood transfusions or shared needles, and from mother to child. Thank goodness that's it. If this virus spread through water, through the air or through casual contact, then we would have real fears for the future of humanity.

Bishop Browning

Let me make a brief response to the questions. I think our educational approach in the Episcopal Church has been exactly to try to deal with those fears. But even after sharing with our parishioners this teaching there's still the fear. So pastorally we have said to our people that if this is still something that bothers you then take the sacrament in one kind or use intinction. That's the way we've tried to respond in a pastoral way to the fear that some people still possess even after we've shared the best information with them.

Dr Gordon

Just one addition and it's not an either/or model. Again the bishop of California - I sound like his public relations person and I'm not even an Episcopalian - on this very issue of the common cup he sent out a letter giving the most up-to-date scientific information à la Dr Mann, and adding, "I will keep studying the question, I will be open to every new piece of evidence but since this is what we know scientifically at the moment I want you to know that every place I go in this diocese where I receive communion, I will receive from the cup as the last person in the congregation." I think those are the moments for prophetic church action.

Question

My first question: why are people against screening? Don't you think it is the best way to prevent the disease? Secondly, the first article I read about Aids was in 1981 when the first case in the United States was reported. Don't you think it was very

misleading that it was mentioned that only homosexuals are prone to the disease? Nothing was mentioned about drug-abusers and infection by the sharing of needles and blood transfusion.

Dr Mann

Excellent questions. Let me answer the second one first - the medical facts. What we know now about Aids is the result of an enormous amount of international scientific work. In 1981 when the disease was first recognised it was indeed thought, although it was a mistake, it was thought to be a disease of male homosexuals in two places, California and New York. Very rapidly over the next two years 1981 to 1983 the following discoveries were made. But they were discoveries remembering again that we are at a historic moment at the beginning of a worldwide epidemic and what we know is only what we can have learned in a very short time. Later in 1981 and actually in 1982 it became clear that blood transfusions could transmit the virus. Even later it became clear that haemophiliacs and therefore certain blood products could transmit the virus. Later or about that time it became evident about intravenous drug-users.

Aids in Africa was not discovered until late 1983. By discovered, I mean recognised first in late 1983. Therefore we didn't know how the virus was transmitted until the facts became available. So what I presented to you and what you hear from everyone about the way it spreads is the result of a growing understanding. It was not all available at the beginning. And because of that we have suffered enormously. Because we didn't know everything right away. The suffering comes from the stigmatisation of one country and of one group in society as the source or as the main people affected by Aids. If you look worldwide there are many more heterosexually transmitted cases of Aids than there are homosexually transmitted cases. And so we have been battling that misunderstanding for years. But it's due to the natural evolution of knowledge about the disease.

Regarding screening. Let me take the example of any country. When you screen, if you screen in a compulsory way, what you're really telling people is that if you're positive you're going to suffer an enormous range of socially important and personally important consequences. You are going to be stigmatised. And I don't care what government it is, if you talk about confidentiality and in some record there is a name and a test result you have to have genuine concern about whether that confidentiality will be kept. If you screen people and you divide them into the infected and the non-infected, first some of the infected are not infected because of the tests, and some of the non-infected i.e. the negative test people, are actually infected. So even there you've made a mistake. What are you going to do with the people who are positive? Are you going to put them on an island? Are you going to pass a law and try to prevent them from having

sexual relations with anyone? What are you going to do with them? When you think the consequences through of that and then you look at the fact that because the disease is moving through society you would have to re-test everybody every six months in order to determine who was infected and who was not infected - then you enter into the realities of dealing with this disease.

And I would put the question therefore back to you. Would it not drive those people who are most afraid that they might be infected underground to hide from a screening process? Can a society force everyone in that society to undergo a blood test? Can a society guarantee the quality of the blood test and the confidentiality of the results? What are you going to do with people who are found to be infected? Are you willing to invest the money to screen everybody every six months for the rest of their lives? I put those questions back to you as one way of addressing what I think are the social and ethical rather than the medical issues associated with this idea.

Question

I have known people who have died of unknown causes and yet the popular myth was that they probably died of Aids. In your studies what are the causes of the spread besides sex or transmission through blood? There are rumours now saying that mosquitoes are spreading the disease and also probably other insects. Can you substantiate that?

Dr Mann

All the evidence we have, evidence from not only Africa but also South America and Europe and the United States where mosquitoes and other insects are often in abundance, all the evidence we have fortunately suggests very clearly or demonstrates that the virus is apparently not being transmitted through insects. Thank goodness. I have to tell you that there are some people who would like the virus to be transmitted by insects. They would like it to be transmitted by insects because if it was it would remove human responsibility. It would make it a disease in which you didn't have to think about sexual practice, you wouldn't have to think about the economics of screening blood or the issues of making sure that every injection is given with a clean needle and syringe. What are we to recommend to a woman who is infected with this virus and becomes pregnant knowing that there are severe dangers to her of becoming pregnant if she is infected with the Aids virus? Knowing that she has about a 50% chance of infecting her child from birth with this, knowing as we're beginning to learn that there is probably also a syndrome of childhood malformation associated with infection with this virus, what are we going to tell people? There are those who'd like it to be transmitted in some other way so that the individual responsibility could be reduced.

The virus does not appear to be transmitted by mosquitoes. What we have learned from studies in Africa as well as elsewhere is

that wherever you are in the world the modes of transmission are the same: sexual, blood, which in the United States may mean intravenous drug-users sharing their needles, in Africa there is very little intravenous drug-use but there are needles that are used to give medical injections or para-medical injections that because of economic reasons or other reasons are not being cleaned and sterilised between each use, and that needlestick from one person to the other is capable of transmitting the virus. And, finally, it's spread from mother to child. I think it's actually very reassuring that the disease is spread the same way everywhere. The problem is how to stop it. And that has to do with a great deal of individual responsibility as well as certain actions that governments and institutions can take.

Question

What kind of physical suffering does a person with Aids experience and what are the indications ?

Dr Mann

When a person has Aids, what Aids really means is that their bodies' immune system is failing. And therefore they suffer a series of life-threatening infections that they can't fight off and cancers that normally the body would keep down and not let develop, but because the immune system which attacks cancer cells is down, the cancers come about. The actual ways in which the suffering that a person experiences is first related to the fact that they usually are ill for quite a long time, months at least, before they die.

Aids isn't like a heart attack where the person may be perfectly healthy in appearance and then suddenly dies. There's a period of illness and suffering during which time they not only face the physical symptoms associated with whatever the infection is that they catch - pneumonia, a kind of skin cancer, or a form of infection of the brain - not only do they face those physical symptoms but from the moment that it is recognised that they have Aids they face the fact that because of unjustified fear and ignorance that there will be members of their circle as well as members, unfortunately, even of the medical professions who will no longer touch them. And Aids patients have described to me what is the most painful symptom of their disease - the fact that their friends will no longer shake hands with them. Now we're talking about a kind of stigmatisation that has a psychological impact we can't measure. But I would have to say that if you look at the survival of an Aids patient, and their survival is not long, it's an average of about 8 or 9/10 months after the onset of the severe symptoms, that one of the factors in there must be the stigmatisation, isolation and ostracism they experience. So, the symptoms are very varied. Death is not quick. Death is inevitable and death is accompanied by a kind of rejection that can be the most painful symptom of all.

Dr Gordon

Given that medical description I think we can see why, to play with Bonhoeffer just for a moment, while certainly ours is not cheap grace Bonhoeffer talks about God as being the nearest Thou at hand and so we have good news. We must not become part of the problem rather than the answer because it may well be that the last human contact they have would be with the church that has always sustained or possibly has never sustained them but could sustain them for the first time.

Moderator

I'm going to conclude with just two very brief reflections. The first is that I think it is obvious from what has been said that this is a question which affects everybody and that this infection can only be beaten in the long-term by many agencies cooperating. Many of our questions have been directed towards the medical profession because they have the expert knowledge at the moment. But it seems to be quite essential that church people should be themselves well informed about this and that churches should take a lead in the educational programmes which are so necessary. Now that leads to a little internal politics in the WCC because here we are a small group of the Central Committee and it seems to me that what we have now got to do is to take to our sections and departments some of the concern which I hope this Hearing has aroused in us and make sure that what is said here goes out worldwide.

The second thing I would want to say is just a very brief theological footnote to what has already been very movingly said by Dr Gordon. The Aids virus is fragile. For its transmission it depends upon intimate contact. And there is an interesting connection between intimacy and vulnerability. Every intimate contact makes us vulnerable in all sorts of ways not only through transmission of infection but also psychologically and in our personal identity. And this is why every civilization has in various ways surrounded intimate relationships with rules, with structures, with ceremonies, with taboos. These have as it were protected the relationships. And what I see the Aids epidemic as teaching us is that we cannot lightly treat these intimate relationships any longer. And that is where the world has lost its sense that close contact between human beings needs to be within an ordered framework. Then it is sure to recover that perspective. And this it seems to me is a moral and theological understanding which can be expressed in ways which are accessible not only to those with Christian commitment but to all those who think seriously about our human nature and our contacts with one another. I leave that there as a final theological reflection, and I would like to thank very much our speakers who introduced the subject and particularly Dr Mann

who has borne the weight of the questioning and who bears this very heavy responsibility in the WHO. I hope we can all remember him and his team in our prayers in this enormous task that they have to carry.

Thank you very much indeed.

CLOSING CENTRAL COMMITTEE SUMMING UP ON AIDS*

In responding to issues raised from the floor, I do so as Chairperson of the Drafting Committee of the statement "Aids and the Church as a Healing Community," from the consultation on "Ethics and Aids," Geneva, June 1986, requested by the three sub-units, Church and Society, Family Education, and the Christian Medical Commission. This statement was reviewed by the Church and Society Working Committee, and transmitted to the Executive at its September 1986 meeting, Reykjavik, where it authorized its circulation.

I want first of all to express gratitude and admiration to the General Secretary, who in response to several member churches and the World Health Organization (WHO) had the courage and foresight to address this problematic issue of Aids. Questions from the floor have asked where the statistics on Aids are from, how reliable are they, and how can we be accurate about them, without being unduly offensive to various continents involved?

The statistics are from the WHO, and what we can be absolutely sure of is that they are conservative figures. WHO publicly admits to vastly conservative initial estimations, and now terms the world situation "pandemic", not withstanding the fact that some countries are grossly under-reporting their cases because of fear of stigma, national pride, and fears of publicity that threaten loss of tourism and valued foreign exchange.

The statement "Aids and the Church as a Healing Community" that we propose for commendation by the WCC Central Committee is an ecumenical effort of 18 persons from three continents. The June Aids Consultation included pastors and theologians from Europe; from North America, especially New York City and San Francisco, the cities with the largest diagnosed cases; and Christian medical doctors and researchers from Zaïre and from Trinidad, who were just returning from the WHO Aids Conference in Paris with the latest research information. Our statement was a delicate and successful effort of staying with the facts, their implications and repercussions, without unduly offending the sensibilities and sensitivities of people with very different regional experiences.

I want to speak to the characterization that this statement is one that is basically pastoral, and that it avoids addressing the moral issues. I speak to that characterization as a Roman Catholic, and as a systematic theologian associated with Union Theological Seminary, New York City. As a theologian, I am vitally interested in theology and morality, and not only with pastoral issues, as important as they are. This Aids statement is not only a pastoral statement. Unfortunately, when we think

*The final plenary intervention by Dr Kevin Gordon to the WCC Central Committee at the invitation of the moderator of the Plenary session, January 24, 1987.

of morality, we too often think of the sexual activities and the behaviour of people. I cannot stress too much that the statement's call for "free exchange of medical and educational information about the disease within countries and across borders... the freedom to pursue research... the free flow of information" -- these are the moral issues in view of under-reporting that enormously impedes the information we desperately need for seeing the full picture, for research, and for finding a cure. Our call is not only for "responsible forms of behaviour by all", for "altered behaviour patterns", but also "for the improvement of physical and socio-economic conditions in many parts of the world", where Aids will soon account for more deaths in developing countries than from all other infections put together -- this too is a moral issue.

The need that we be sexually explicit in our education for prevention, so that "the different modes of transmission prevalent regionally be clearly described and understood" -- that is a moral issue. Our conscious decision as a Consultation not to moralize in our statement, was a moral stance, as was our refusal to give any theological support to a rigid and narrow 'tit-for-tat' God who sends Aids as an act of divine retribution. Such an assertion is shocking to unbeliever and believer alike. Surely with Job we have learned in the fact of profound incomprehensibility to put our finger to our lips. We "affirm that God deals with us in love and mercy and that we are therefore freed from simplistic moralizing about those who are attacked by the virus".

Aids, then, is on the ecumenical agenda because of the alarming rate at which the disease is increasing, and also because much of the discrimination against people with Aids, shockingly claims religious foundation. Our statement on "Aids and the Church as a Healing Community" is as important for what it does not say as for what it does say. We must be part of the answer -- Good News -- and not part of the problem. Some may think that this disease provides a natural occasion for the churches to judge Aids; ironically, and in the long run, it may be Aids that judges the churches".

UNIT I COMMITTEE PREAMBLE

To the Statement on
"Aids and the Church as a Healing Community"

1. In response to requests from member churches and the WHO, the General Secretary asked the sub-units on Church and Society, Family Education and the Christian Medical Commission to undertake a study of Aids. The three sub-units therefore held a joint consultation in June 1986 on the theme "Aids and the Church as a Healing Community". The findings of this consultation were summarized by the Church and Society Working Committee and authorized for circulation by the Executive at its September 1986 meeting.

2. Since that date the size and urgency of the problem has become even more apparent and it seems likely that the world is about to face the most serious health crisis of modern times. Most known cases are at present in North America, Europe and Africa, but cases have also been reported in Oceania and in Asia. Unless vigorous preventive measures are taken, the advance of Aids is likely to be rapid in all parts of the world. One of its most dangerous features is the long latency period between infection and the first appearance of symptoms. This can be at least five years, with the result that many people can become infected, and can pass on the infection, long before they are aware of the fact.

3. In the face of this major health threat the churches have three roles to perform: pastoral, educational and social. These are usefully summarized in the report from the June international consultation.

The Unit Committee recommends that Central Committee urges all churches to make known the seriousness of the problem of AIDS and to take every opportunity to cooperate with one another and with medical, social and educational agencies and the mass media in appropriate educational programmes. (Carried unanimously)

Note: Cases reported by the WHO as of January 16, 1987 by continent are as follows:

Americas	31,741
Europe	3,858
Africa	2,324
Oceania	395
Asia	85
Total	38,403

AIDS AND THE CHURCH AS A HEALING COMMUNITY

The Executive Committee of the World Council of Churches, having received a report on the consultation held in Geneva in June 1986 on "Aids and the Church as a Healing Community", wishes to call the attention of the churches to the urgency of this issue.

We call on the churches to respond appropriately to the need for pastoral care, education for prevention and social ministry as called for by the consultation.

The Executive Committee also asks the General Secretary of the WCC to plan for appropriate follow-up of the recommendations of the consultation by the sub-units on Church and Society, Family Education and the Christian Medical Commission.

The Medical Background

The consultation provided important medical information, including the following:

"The rate of spread of Aids and its high fatality is frightening. Aids is a viral infection which recently appeared, being identified only five years ago. It is sometimes considered to be the plague of the 20th century.

"According to reports from the World Health Organisation, Aids is present on all continents where it is contracted by men, women and children, regardless of socio-economic status, education, culture or religion. The number of people ill is increasing geometrically, doubling every 10-14 months. At this time, the world has about 30,000 persons with Aids (24,000 in the USA, 2600 in Europe and 1000 reported cases in Africa)*.

"This number is probably underestimated, as many countries have not been able to give complete information. The number of persons infected by the virus who have no clinical manifestations (so-called carriers) is unknown. It probably numbers in the millions. It appears that a great number of people are infected annually. The rate of infection may vary significantly from one place in the world to the next.

"In Africa the illness is contracted primarily by a heterosexual population; in Europe, North America and Oceania primarily by male homosexuals and intravenous drug-users. Mortality is high reaching 75% one year after diagnosis and 100% three years after diagnosis. No efficacious treatment has been found. The hope of a vaccine is very uncertain. So far only preventive measures can help to stem the epidemic."

The Church as a Healing Community

The consultation identified the following theological foundation for the Church as a healing community: "In the

*For more recent figures, see pg.23.

mysteries of life and death we encounter God; this encounter calls forth trust, hope and awe rather than paralysis and immobilization. Those we cannot cure we can support and sustain in solidarity: "I was hungry....thirsty....a stranger.... naked....sick....imprisoned, and you fed....clothed....took care....visited" (Matthew 25).

"The Aids crisis challenges us profoundly to be the Church in deed and in truth: to be the church as a healing community. Aids is heartbreaking and challenges the churches to break their own hearts, to repent of inactivity and of rigid moralisms. Since Aids cuts across race, class, gender, age, sexual orientation and sexual expression, it challenges our fears and exclusions." The healing community itself will need to be healed by the forgiveness of Christ.

The consultation called on the churches to undertake the following:

1. Pastoral Care

"The people of God can be the family that embraces and sustains those who are sick with Aids-related conditions, caring for the brother, sister or child without barriers, exclusion, hostility or rejection.

"Death is a mystery. We are angry and helpless when faced by its reality. We need to acknowledge our helplessness and not deny it. This has particular significance as we share the experience of ministry with persons with Aids and as we are ministered to by them", as we grow with them in our christian understanding of death in the light of Christ's death and resurrection.

2. Education for Prevention

"To assure high quality information on the disease, we invite the churches to participate actively with the health professions, local governments, where possible, and local community agencies in programmes of prevention education. We invite the churches to use the World Health Organisation and its network of local resources.

"Aids is preventable. Society must concentrate sufficient resources on its prevention. This will involve measures that should reasonably be adopted by all: carriers, the sick, current high risk groups and the general population, since the latter includes many undetected carriers. It also calls urgently for responsible forms of behaviour by all, and for the improvement of physical and socio-economic conditions in many parts of the world.

"Preventive measures and altered behaviour patterns must address the different factors that favour the transmission of the virus; it is necessary, therefore, that the different modes

of transmission prevalent regionally be clearly described and understood."

3. Social Ministry

"Given the widely varying valuations of some of the issues related to the disease, member churches and ecumenical councils will have to be rigorously contextual in their response. We affirm, however, certain commonly held values, especially:

1. the free exchange of medical and educational information about the disease within countries and across borders;

2. the freedom to pursue research about the disease;

3. the free flow of information about the disease to patients, their families and loved ones;

4. the right to medical and pastoral care regardless of socio-economic status, race, sex, sexual orientation or sexual relationship;

5. the privacy of medical records of persons with Aids or Aids-related Complex or positive antibodies.

"Since Aids is a global epidemic, effective action by churches and individual Christians must extend not only to the Aids neighbour closest at hand, but also through effective global collaboration to the stranger on the farthest side of the world."

The consultation also called on the churches "to work against the real danger that Aids will be used as an excuse for discrimination and oppression and to work to ensure the protection of the human rights of persons affected directly or indirectly by Aids."

The Executive Committee also wishes to call to the attention of the churches these further concerns expressed by the consultation:

> "to confess that churches as institutions have been slow to speak and to act: that many Christians have been quick to judge and condemn many people who have fallen prey to the disease; and that through their silence many churches share responsibility for the fear that has swept our world more quickly than the virus itself;
>
> "to affirm and support the entire medical and research community in its efforts to combat the disease;
>
> "to affirm that God deals with us in love and mercy and that we are therefore freed from simplistic moralizing about those who are attacked by the virus."

RECOMMENDED READING*

Aids: A Resource Packet for Congregations, Division of Church & Society, National Council of Churches of Christ, 475 Riverside Drive, New York, N.Y. 10115 (free on request).

Ministry: A Time for Caring, Office of Communication, Episcopal Church Centre, 815 Second Avenue, New York, N.Y. 10017, (free on request, English and Spanish).

Women and Aids (series, including videos), The Family's Guide to Aids, San Francisco Aids Foundation, 333 Valencia Street, Fourth Floor, San Francisco, California 94103 (prices on request, English and Spanish).

Aids: Some Guidelines for Pastoral Care, Board for Social Responsibility of the Church of England, Church House Publishing, Church House, Great Smith Street, London SW1P 3NZ, 60p each.

The Ethical Challenge of Aids: the Disease, its Epidemiology and Treatment, Courteney Bartholomew, Cecile de Sweemer et al., WCC (free on request).

Aids and the Third World, Panos Dossier 1, Panos Institute in association with Norwegian Red Cross, 8 Alfred Place, London WC1E 7EB, November 1986 (price on request).

Breaking the Silence, Overcoming the Fear: Homophobia Education, Church Education Services, Ministries with Congregations, the Program Agency, Presbyterian Church (USA), 475 Riverside Drive, New York, N.Y. 10115, $3.50.

Aids: Public Health and Civil Liberties, Carol Levine, Hastings Centre, 360 Broadway, Hastings-on-Hudson, N.Y. 10706, $6.00 per copy, see also the references and other publications by the Hastings Centre.

*Please keep us informed of relevant material.

WORLD COUNCIL OF CHURCHES

Programme Unit on Faith and Witness

Sub-unit on Church and Society

150, route de Ferney
P.O. Box 66
1211 Geneva 20

Telephone : (022) 91 63 40
Telex : 23 423 OIK CH
Cable OIKOUMENE GENEVA

BIBLIOTHÈQUE
du Conseil Oecuménique des Eglises
150, route de Ferney
1211 GENÈVE 2

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